MARKET CONDUCT UNIFORM EXAMINATION OUTLINE

A. Examination Scheduling

1. Each state shall prioritize examinations

    a. Each state shall establish criteria for calling a market conduct examination. (See exhibit A1 for an example of items that may be considered.) States shall establish a priority or weight for each of the criterion being considered.
    b. Each state shall prepare a schedule of examinations and select a person responsible for developing and maintaining the schedule. Exceptions may be made when an examination is called as a "no-knock" examination.
    c. The trigger or reason for the examination shall be maintained in the examination documents, preferably the workpapers.

2. States shall utilize the exam tracking system (ETS)

    a. As soon as scheduled, each state shall enter the examination into the ETS, which is administered by the NAIC.
    b. Each state shall adopt a system for ensuring proper implementation and maintenance of the ETS system. The NAIC will develop aids such as a data entry checklist that will assist in maintaining the ETS program.

3. Timetable for maintenance of the ETS

    a. Exams shall be entered into the ETS no later than 60 days before the expected date of the onsite examination. Exceptions to this rule are examinations that are called to respond to more immediate conditions.

B. Pre examination Planning

1. Internal planning by states on companies selected for examination.

    a. Each state shall develop a standard planning process. Many of the items reviewed may have been used in the examination priority process shown in A.1.a. and may become the basis for the pre-examination planning. In addition to the items found in exhibit A1, the following information may be considered:
        - Information from prior examinations;
        - NAIC databases;
        - Internal database such as the complaint index;
        - Discussions with other department of insurance personnel;
        - The financial statement;
        - Interview with the company (see exhibit B1 for an example); and
        - Information received from other states' examination.

b. The plan should be maintained in a manner that may be incorporated into the workpapers.
c. At the end of the planning process, the state shall determine the phases and/or standards of the examination that require more attention, the phases or standard that require average examination scrutiny or attention and those that require a reduced emphasis or may be waived. See the following list:
   - Special emphasis-larger samples, more scrutiny, more examination time allotted;
   - Standard emphasis-initial sample follows NAIC guides, average scrutiny and examination time allotted; and
   - Reduced emphasis-smaller samples, review may be limited to procedures only, reduced scrutiny and examination time allocation.
d. Each state shall prepare an examination workplan prior to the examination. The workplan or planning memorandum shall include:
   - The scope of the examination;
   - The justification for the examination;
   - A time and cost estimate; and
   - An identification of factors that will be included in the billing.

2. Each state shall develop a system to announce the examination to the selected company.

   a. The announcement of the examination should be sent to the company as soon as possible but in no case not any later than 60 days before the estimated commencement of the onsite examination. The announcement notice should contain:
      - The name and address of the company(ies) being examined;
      - The name and contact information of the examiner-in-charge;
      - The date the onsite examination is expected to begin;
      - The statutory authority for the examination;
      - The identification of items that will be billed to the company, if any;
      - A request for the company to name its examination coordinator; and
      - Additional information may be requested at a later date.

3. Each state shall develop a preliminary examination packet or handbook that should be sent to the examination coordinator as soon as possible but in no case not any later than 30 days before the estimated commencement of the onsite examination.
   a. The preliminary information shall contain the following information:
      General instructions
      - The scope of the examination
      - The materials requested to perform the examination
      - Data calls
      - Requirements for accommodations and supplies including modem requirements
      - Time and cost estimates
      - Travel information
      - Specific instructions regarding sampling, communications with the company and other pertinent information
      - Location of on-site examination
      - Security arrangements

- Billing procedures

4. Data calls
   a. States shall adopt a standardized data call. The data call will be broad and states may choose not to use all fields.
   b. If a state deviates from the standardized data call, it will notify the company of the deviation and may want to allow additional time for the company to provide the information.

C. Examination procedures

1. The state shall conduct a pre-examination conference with the company coordinator and key personnel to clarify expectations prior to the commencement of the examination.

2. The state shall develop a system for exchanging information with the company that advises them of the errors and other problems developed during the examination. The system could consist of "crit" sheets, summaries, or both. Any form of communication concerning errors should include the following information:
   - Record numbers or other identifying factors;
   - The examiners' statement of the problem or error and, if relevant, the applicable law and/or standard; and
   - A request for signature and comment from the company.

3. Each state shall develop a procedure for document handling including the removal of original documents to a location other than the state insurance department. To address the issue of confidentiality, original work paper documents shall remain at the state insurance department, especially if the examiner is a contracted employee of the state department.

4. States shall use the NAIC sampling guidelines or develop their own scientifically based sampling program.
   a. All sampling methods should be random.
   b. If using a method other than the NAIC sampling guidelines, the method shall indicate the confidence levels, tolerable error rates and include extrapolation.
   c. All sampling methods shall avoid pre-selection, however, stratified sampling is allowed.

   (See Chapter 5 of the *NAIC Market Conduct Examiners' Handbook* for further discussion.)

5. Each state shall offer to conduct an exit conference at the end of an examination. The exit conference should offer the following:
   - The examination status and proposed findings;
   - The report process; and
   - An explanation of any post examination billing.

D. Exam reports

1. The states shall utilize a standard format found in the NAIC handbook as follows:
   - Title page;
   - Table of contents;
   - Salutation;
   - Foreword;
   - Scope;
   - Executive Summary;
   - Results of Previous Examinations;
   - Pertinent facts of the current examination;
   - Summarization; and
   - Appendices.

   a. Reports may be written by test or by exception. States shall report the method utilized to the company and in the scope of the report.

2. States shall utilize a standardize timeline as required by the state's statute or the NAIC model as outlined below:
   a. The draft report is delivered to the company within 60 days of completion of the examination;
   b. The company must respond with comments to the state within 30 days;
   c. The Insurance Department has 30 days to informally resolve issues and prepare a final report (unless there is a mutual agreement to extend the deadline); and
   d. The company has 30 days to accept the final report or request a hearing.

3. The states shall include the company's response in the final report. The response may be included as an appendix or in the text of the examination report. If it is not in the final report, the report should indicate that a response is available. The company is not obligated to submit a response. Individuals involved in the examination should not be named in either the report or the response except to acknowledge their involvement.

4. States shall publish reports as public documents where allowed by law.
   a. States should publish examination report on the insurance departments' websites.
   b. States shall develop a process for releasing examination results to the public. A press release may be used.

5. States shall devise an enforcement strategy, and specifically the role of market conduct activities in that effort. The primary role of examiners is to be fact-finders when determining compliance, which can then be used by the department to determine sanctions or fines. An enforcement strategy would have to have a system in place to differentiate between willful actions and inadvertent ones, and considering appropriate administrative resolutions whether it be financial or non-financial. States should also want to consider a methodology for determining the amounts of fines, based on a host of criteria including the size of the company, the market share, whether the problems have been corrected, and any host of

mitigating or aggravating circumstances. States should also be certain to communicate the basis of any assessed penalty. (See exhibit C1 for enforcement examples as submitted by various states, additional examples to be included at a later date.)

6. Each state shall establish a follow up examination process.

EXHIBIT A1
REASONS FOR EXAMINATION

1. COMPLAINT INDEX – States should review the complaints to determine where problems exist. Insurance Department may develop an index for each company measuring the number of complaints to that company's market share by premium volume.

2. RECENT COMPLAINTS - An increase in recent complaints filed against an insurance company may suggest concern. In order to address those complaints, an examination may be necessary in order to obtain remedial action.

3. MARKET SHARE - Due to its volume of premium, the practices of a particular insurance company can impact a large number of citizens. If the state needs to review a particular line of business or particular type of product, the state may choose those companies with the most premium volume.

4. FINANCIAL EXAMINATION - The financial examiners may discover an issue during an examination, which warrants further review from a market conduct perspective. Such a market conduct examination may occur simultaneously with the financial examination. The financial examiners may incorporate the findings of the market conduct examiners into the financial examination report.

5. INFORMATION FROM OTHER STATES - Findings by other state regulators may generate a need to discover whether the same or similar practices are occurring in another state. One state may extend an invitation to the other states to participate in a multi-state examination.

6. LEGAL REQUEST - The Legal Section may discover a particular illegal practice, which warrants further discovery through an examination.

7. SHIFT IN BUSINESS PRACTICES - A company may change its product mix resulting in a significant change in its operations. If a company has not adequately managed for such change, it may not have the expertise to properly and fairly treat its consumers. An examination may address problems before the problems become widespread.

8. PRINCIPALS INVOLVED - The state may become aware that individuals have had a past history of regulatory noncompliance. The NAIC maintains information systems identifying suspect individuals and past regulatory actions. An examination can identify improper activity prior to its impact on a large number of consumers.

9. INFORMATION FROM STATISTICS – State may maintain several databases. For example, Missouri law requires the reporting of certain information such as financial statements, premium volume and amounts of claims paid categorized by zip code, malpractice claims, etc. Statistical tests evaluate aberrations that may necessitate further discovery by means of an examination. Illinois and Ohio utilize a market conduct annual statement.

10. POLICY APPROVAL SUGGESTIONS - The policy analyst may note a trend in policy form filings that may necessitate further discovery by means of an examination.

11. REQUEST OF THE DIRECTOR - The Commissioner of a state may ask for an evaluation of certain practices or certain products.

12. RESULT OF LAST MARKET CONDUCT EXAMINATION - Based upon a review of the findings of a prior examination, the state may determine the need for further review.

13. INDUSTRY SUGGESTION - Insurance company personnel may bring to the state's attention a particular practice or product that may need a further evaluation.

14. MEMBER OF GROUP BEING EXAMINED - Typically many insurance companies operate under an umbrella holding company sharing the same personnel and similar operational management. While examining one insurance company, it may be more cost effective to review several companies of the same group.

15. PERIODIC - LENGTH OF TIME SINCE LAST EXAMINATION - The mere passage of time without an examination in conjunction with other factors may indicate the need for an examination.

16. NEW OPERATION - NEVER EXAMINED OR UNDER NEW MANAGEMENT - Much like the Shift in Business Practices described above, a new company or a new management team may not have the expertise to properly and fairly treat its consumers. An examination may address problems before the problems become widespread.

17. REEXAMINATION - UNDERSTANDING AT TIME OF STIPULATION - In some cases, during the negotiation of an examination's resolution, the examined company and the Department will agree that some mitigating circumstance created the cited noncompliance. The company indicates that it is now in compliance. In order to verify that remedial action has occurred and that the company accomplished full compliance, the state may perform a second examination.

18. EVALUATION OF NEW LAW - The state may target an examination in order to determine the compliance with and the effectiveness of recently enacted statutes.

19. MEDIA – States may receive information through a news broadcast or the trade journals which prompt further evaluation.

EXHIBIT B1
OREGON PLANNING PROCEDURES
INTENDED AS AN EXAMPLE ONLY

Planning an examination

The purpose of an examination planning procedure is to minimize time spend at the examination sight and maximize the limited personnel resources for each examination. Please note, this document is created as a guide only. In order to achieve this, the Examiner-in-Charge (EIC) for each examination will be required to perform a planning procedure outlined below. At the end of the planning, the Examiner-in-Charge will produce a planning memorandum, which outlines the significant areas to be reviewed and provides a brief justification for each area. After the acceptance of the memorandum by the Chief Market Conduct Examiner and Consumer Protection Manager, the company will receive a customized resource list and the actual examination date will be scheduled.

Instructions

At the conclusion of the planning phase, a notebook should be completed containing the planning memorandum, all supporting documentation and the time budget. Each item should be identified by the corresponding number shown below. Any additional information developed may be included at the end of the corresponding section. It will be the EIC's responsibility to review the planning notebook with the examiners immediately before or on the first day of the examination.

I. Insurance Department Resources

1. Company Section

1a.	Review the last annual statement. Determine the premium for the last year by lines of business.
1b.	Interview assigned analyst, if any, to determine if there have been any new product introduced, solvency issues, changes in management structure or ownership.

2. Consumer Protection

2a.	Request a complaint run covering the period of the examination.
2b.	Interview compliance officers to determine if there has been any trends in complaints received about the company proposed for examination or within the industry. Ask them for any supporting documentation.
2c.	Interview investigations to determine if there are any judgements have been entered against the company or if there are any current investigations.
2d.	Ranking from last published complaint index and indices.

3. Rates and Forms

3a.	Request a list of all forms in use during the examination period. **Note: This includes forms that were approved during and before the examination period and are still in use.**
3b.	Interview rates and forms analyst to determine what types of changes have been noted in the rate and forms filing of the company during the examination period.
3c.	Interview rates and forms manager or asst. manager to determine trends in the industry.

4. Agency Licensing

4a.	Request a list of active appointed agents (agencies) during the examination period. **Note: This includes all agents approved before the examination period who are still active.**
4b.	Request a list of all agents whose appointment was terminated during the examination period.

5. Miscellaneous

5a.	Request the following NAIC reports: CDB, SAD, RIRS, and ETS.
5b.	Review Wang system for comments relating to the company.
5c.	Interview actuaries to obtain any trends or knowledge of the company the actuary might possess.
5d.	Read the last market conduct exam and workpapers, if any. Also review any follow up information. Make a list of the recommendations and the items passed with comment which were suppose to resolved during the course of the examination.

II. On-site Operations

1. Company Operations

1a.	Determine financial structure of the company, including relationships to parent, subordinate, or affiliated companies.
1b.	Determine lines of business written (i.e. auto, homeowner, small group, large group, individual health, group life, individual term life, disability, etc). Request a list include the last annual premium written by line and the number of policies currently in force.
1c.	Determine what function(s) the company may have delegated or outsourced.
1d.	Request a memo outlining any changes in corporate structure, management, products, marketing, and geographic territory since last examination.
1e.	Determine where examiners need to go to review company records

2. Marketing and Advertising

2a.	Determine what forms of advertising the company uses (newspapers, televisions ads, radio, internet, etc.).
2b.	Determine if the company maintains an advertising log. Ask to see documentation and determine if the information in the log will be sufficient to review the advertising materials.
2c.	Review the company's website for advertising or marketing information that may need to be included in the review. Has the company substituted the website for any hard copy information? If so, have they made arrangements for alternative methods of delivery in the event an enrollee does not have access to the internet?
2d.	Is the website used to market products, sell direct, price products or enroll members? If so, determine how this is done.
2e.	Determine what other promotion information the company produces (brochures, sales packet, videos?) Determine how the material is used (through agent or sent directly to prospects). Document the number and type of marketing pieces used.

3. Complaints (also known as Grievance and Appeals)

3a.	Ask the company for a list of its Insurance Department complaints and compare it to the number prepared by the department internally. A match or close match is a good indication of compliance. However, a large discrepancy usually means some time must be allowed for the examiner to discover the reason for the difference.
3b.	Determine the number of internal complaints. Determine if they keep a log. Probe the company to ensure all types of complaints are maintained in the log. (For example, are complaints against agents maintained in a separate log in the sales department?)
3c.	*For Health only.* Determine the number of internal complaints or grievances as step 1, step 2 and step 3. Ensure the company has identified and logged all 3 steps. If there is an external appeal log, request it and log the number of items that have been sent to external review.
3d.	Determine if any customer satisfaction surveys have been performed in the last 2 years. Request a copy for review.
3e.	Review any internal complaint or grievance reports that were produced.

4. Agency Licensing

4a.	Determine what type of sales force the company uses. (Captive agents, in house agents, independent sales force, etc.)
4b.	Determine lines of business written (i.e. auto, homeowner, small group, large group, individual health, group life, individual term life, disability, etc.). Request a list including the last annual premium written by line and the number of policies currently in force.
4c.	Determine what function the company may have delegated or outsourced.
4d.	Determine where examiners need to go to review records.
4e.	Determine the size of agency force.
4f.	By interview, determine if the agency force receives formal training. Determine if it will be necessary to review the training records.
4g.	Thoroughly interview determining how appointments and terminations are arranged.

5. Underwriting

5a.	Review the underwriting process. Determine what kinds of decisions are being made (risk selection, rating).
5b.	How are underwriting decisions recorded? Especially exceptions to the underwriting rule?
5c.	Is an expert system used?
5d.	Some states manually verify rates. Does the company have rating sheets available? Is there anyone on staff who can manually rate your products?
5e.	What underwriting tools are used (MVRs, credit reports, health statements)
5f.	Review how policy files are kept –electronically or paper? If electronically, how many screens must be reviewed per file? How is history retained? Please provide a sample screen printout for each screen.
5g.	Does the company have any unique and or negotiated forms?
5h.	How does the company identify what forms are sent with the policy?
5i.	*Heatlh only* How does the company distinguish between SEHI and HIPPA small employers?

6. Claims

6a.	How many claims are processed in a year?
6b.	Explain the claims process.
6c.	Can the company identify claims that are denied (not closed without payment)?
6d.	Is an expert claim system used?
6e.	How do you maintain your claims records-paper, electronic? If claims are maintained electronically, how many screens must be access to review an entire claim (don't forget, pip, subro etc). Please provide a sample for every screen. Some states manually verify rates.
6f.	Where are letters to the insured maintained? Can you document that a letter was sent?
6g.	What identifiers do are needed to pull a specific claim (name, number etc)?

EXHIBIT C1
ENFORCEMENT PROCEDURES
INTENDED AS AN EXAMPLE ONLY

MISSOURI ENFORCEMENT OPTIONS

The procedures in Missouri are as follows:

A **Filing Order** will be issued when we have conducted an examination and found either 1) no violations or 2) no violations that exceed the acceptable tolerance ranges established by the NAIC. For underwriting errors a tolerance level of 10% has been established, for claims it is 7%. It should be noted that the market conduct examination report is a report by exception. Failure of the report to comment on specific products, procedures or files does not necessarily constitute approval thereof by the Missouri Department of Insurance.

A **Cure Order** will be issued when we have conducted an examination and found errors that exceed the tolerance levels, as stated above, but a forfeiture does not appear to be warranted. The Cure Order requires the company to take the required action that the Director considers necessary and appropriate to cure the violations of law as found in the examination report.

A **Settlement of Stipulation** signed between the insurer and the department when the examination finds errors that exceed the tolerance levels and the department feels that a forfeiture is warranted either to ensure compliance, because a prior examination found some of the same violations, or the current violations show a disregard for compliance with the laws of this state.

Whenever the sampling of files is utilized, the Department uses the following formula for its forfeiture calculation: the found error percentage minus a tolerance level (ten percent (10) for underwriting/rating and seven (7) percent for claims) multiplied by the field size. That amount is then multiplied by a dollar amount ranging from twenty-five dollars ($25) to one-hundred dollars ($100) depending upon the nature of the violation, as well as the statutory reference. This formula takes into consideration that in any operations some error will occur therefore an error tolerance level is granted. It should be noted that when a company exceeds that tolerance level some disciplinary action will be asserted. For areas where a census review was conducted the number of files found in error is multiplied by one-hundred dollars ($100).

This formula also takes into consideration the size of the company in projecting the findings of the sampling to the field size which is the total files the company has for that particular review. Different sections of the insurance code call for monetary forfeitures from $100 up to $1,000 per violation.

COMMENTS

Companies maintain that there is little uniformity in the closing of a market conduct examination. I agree. While we encourage innovation, we must also work within the confines of the laws of this state, as well as what experience has shown.

Also, many states have statutory provisions that address the amount of forfeitures to be levied against a company. By allowing for variances among the assessment of fines/penalties, a state is better able to address the severity of the found errors without having to resort to a ranking of the statutes found to be in violation. A state may also have a better understanding of any ‘mitigating circumstances’ that may warrant a compromise of the forfeiture rather than mere application of a pre-determined formula.

There have also been comments made that consideration should be given to remedial actions taken by an insurer to correct market conduct violations. I think we try to do this, but then, not every company warrants such consideration. This consideration is decided on such a case by case basis that developing standards would be almost impossible. It should be understood though that this is not a quid pro quo. One does not avoid penalties entirely merely because corrective action is going to be implemented. Where this consideration could be used is when a

MISSOURI ENFORCEMENT OPTIONS (con't)

company, through its own internal compliance program or in the course of an examination, identifies a problem and corrective actions are implemented nationwide.

1. Statutory authority for market conduct examinations - Sections 374.202 - 207, RSMo. The statutory basis for asserting a forfeiture is found at the following Sections of the Revised Statutes of Missouri: 374.280 (general), 375.780 (Chapter 375), 375.881 (foreign), 375.942 (unfair trade) and 375.1012 (unfair claims).

2. Procedures required by law - per Section 374.205.3(3), RSMo, the director may either initiate legal action or enter an order:
(a) adopting the report as filed or with modifications. If the report reveals any violations, the director will issue an order directing the company to take any action the director considers necessary and appropriate to cure such violations;
(b) rejecting the report with directions to the examiners to reopen the examination for purposes of obtaining additional information;
(c) calling for an investigatory hearing;
(d) calling for such regulatory action as the director deems appropriate.

3. The general examination procedures

In Missouri, the examiners review a company's licensing records and practices, underwriting and rating practices, marketing practices, claims payment practices and complaint handling procedures. If, upon review, the examiners find a questionable and/or illegal practice, they write out their objections and submit these criticisms to the company, asking for an explanation. A report is then generated based upon the responses to the criticisms, as well as the examiners' findings.

The company is provided a copy of the report and permitted the opportunity to provide any rebuttal, along with supporting documentation. The report, exhibits that substantiate the examiners' contentions, and the company information is reviewed by the in-house staff who then draft a final settlement document.

WISCONSIN ENFORCEMENT OPTIONS

The range of options for enforcement include an order to comply, forfeiture, suspension, revocation of license. Insurers may enter into a stipulated agreement negotiated on a case by case basis that may include other options such as a compliance plan or agreement to make restitution.

The basic guidelines for enforcement procedure are set out in s. 601.64, (3)(c),Wis. Stat. Each violation of an insurance statute or rule can result in a forfeiture of not more than $1,000 per violation.

Violations of previous examination orders are enforcement actions that occur after re-examination. A compliance order is issued when the examination report is adopted. The order cites s. 601.64, Wis. Stats., and requires that the examinee comply with the report recommendations within a period of time.

Failure to comply with the order can result in any of the items in a forfeiture of up to $1,000 per violation. Each day that the violation continues is a separate offense as stated in s. 601.64(3)(b), Wis. Stat.

Wisconsin statutes:

601.64
601.64 Enforcement procedure.
601.64(1)
(1) Injunctions and restraining orders. The commissioner may commence an action in circuit court in the name of the state to restrain by temporary or permanent injunction or by temporary restraining order any violation of chs. 600 to 655, s. 149.13 or 149.144, any rule promulgated under chs. 600 to 655 or any order issued under s. 601.41 (4). Except as provided in s. 641.20, the commissioner need not show irreparable harm or lack of an adequate remedy at law in an action commenced under this subsection.

601.64(2)
(2) Compulsive forfeitures. If a person does not comply with an order issued under s. 601.41 (4) within 2 weeks after the commissioner has given the person notice of the commissioner's intention to proceed under this subsection, the commissioner may commence an action for a forfeiture in such sum as the court considers just, but not exceeding $5,000 for each day that the violation continues after the commencement of the action until judgment is rendered. No forfeiture may be imposed under this subsection if at the time the action was commenced the person was in compliance with the
order, nor for any violation of an order occurring while any proceeding for judicial review of the order was pending, unless the court in which the proceeding was pending certifies that the claim of invalidity or nonapplicability of the order was frivolous or a sham. If after judgment is rendered the person does not comply with the order, the commissioner may commence a new action for a forfeiture and may continue commencing actions until the person complies. The proceeds of all actions under this subsection, after deduction of the expenses of collection, shall be paid into the common school fund of the state.

601.64(3)
(3) Forfeitures and civil penalties.
601.64(3)(a)
(a) Restitutionary forfeiture. Whoever violates an effective order issued under s. 601.41 (4), any insurance statute or rule or s. 149.13 or 149.144 shall forfeit to the state twice the amount of any profit gained from the violation, in addition to any other forfeiture or penalty imposed.

601.64(3)(b)
(b) Forfeiture for violation of order. Whoever violates an order issued under s. 601.41 (4) which is effective under s.
601.63 shall forfeit to the state not more than $1,000 for each violation. Each day that the violation continues is a separate offense.

WISCONSIN ENFORCEMENT OPTIONS (con't)

601.64(3)(c)
(c) Forfeiture for violation of statute or rule. Whoever violates an insurance statute or rule or s. 149.13 or 149.144, intentionally aids a person in violating an insurance statute or rule or s. 149.13 or 149.144 or knowingly permits a person over whom he or she has authority to violate an insurance statute or rule or s. 149.13 or 149.144 shall forfeit to the state not more than $1,000 for each violation. If the statute or rule imposes a duty to make a report to the commissioner, each week of delay in complying with the duty is a new violation.

601.64(3)(d)
(d) Procedure. The commissioner may order any person to pay a forfeiture imposed under this subsection or s. 601.65, which shall be paid into the common school fund. If the order is issued without a hearing, the affected person may demand a hearing under s. 601.62 (3) (a). If the person fails to request a hearing, the order is conclusive as to the person's liability. The scope of review for forfeitures ordered is that specified under s. 227.57. The commissioner may cause action to be commenced to recover the forfeiture. Before an action is commenced, the commissioner may compromise the forfeiture.

601.64(4)
(4) Criminal penalty. Whoever intentionally violates or intentionally permits any person over whom he or she has authority to violate or intentionally aids any person in violating any insurance statute or rule of this state, s. 149.13 or 149.144 or any effective order issued under s. 601.41 (4) may, unless a specific penalty is provided elsewhere in the statutes, be fined not more than $10,000 if a corporation or if a natural person be fined not more than $5,000 or imprisoned for not more than 4 years and 6 months or both. Intent has the meaning expressed under s. 939.23.

601.64(5)
(5) Revocation, suspension and limitation of licenses. Whenever a licensee of the office other than an insurer, a motor club, an adjuster or an insurance intermediary persistently or substantially violates chs. 600 to 646 or an order of the commissioner under s. 601.41 (4), or if the licensee's methods and practices in the conduct of business endanger, or financial resources are inadequate to safeguard, the legitimate interests of customers and the public, the commissioner may, after a hearing, in whole or in part revoke, suspend or limit the license.

Colorado Bulletin No. 1-98

Enforcement Guidelines for Fines and Penalties

Issued and Effective Date: January 1, 1998

Purpose. The purpose of these guidelines is to promote greater predictability and consistency in the assessment of administrative fines and penalties for certain violations of the Colorado Revised Statutes and the regulations of the Commissioner of Insurance.

The Colorado Revised Statutes, Titles 10 and 12, and other provisions governing entities regulated by the Colorado Division of Insurance and subject to enforcement action, are specific as to the formal remedies available to the Commissioner in the event an insurer or producer is in violation of law. Those formal remedies are available to the Commissioner for his/her enforcement responsibilities in the areas of financial analysis, market conduct, licensing and administration, rate regulation, and consumer service practices of regulated entities.

It is not the primary objective of the Commissioner of Insurance to levy fines and penalties but rather to promote a greater degree of compliance with the law. However, monetary fines are a useful regulatory tool for ensuring enforcement and will be utilized at the discretion of the Commissioner. In addition to assessing penalties for conduct which is not in compliance, the Commissioner anticipates that action will be undertaken by the regulated person or entity (collectively "persons") to bring all activities into compliance, and to make restitution to affected parties, where appropriate. Further, the Commissioner recognizes that resolution of an issue without the expense and formality of a hearing and/or a direct order from the Commissioner is most cost effective for all parties. Therefore, the Division will encourage informal resolution of issues to the greatest extent possible, consistent with the framework provided by these guidelines.

(2) Scope.

(a) These guidelines apply to all entities regulated by the Commissioner of Insurance. They apply to all violations discovered or investigated through financial examinations, market conduct examinations, or Division investigations, both formal and informal.

(b) Penalties provided for under §10-3-109, C.R.S., for late filings of required financial documents are set forth at the end of these guidelines. Companies that provide prior written notice and just cause acceptable to the Commissioner may receive written approval for a delayed filing and the Commissioner or his/her designee may waive late assessments.

(c) All persons and companies are presumed to know all applicable Colorado statutes and regulations.

(3) Definitions. These terms are defined as follows for purposes of these guidelines:

(a) **"Act"** means a single occurrence that is in violation of law or regulation.

(b) **"Commissioner"** means the Commissioner of Insurance of the State of Colorado, or his/her designee.

(c) **"Error Ratio"** with respect to sampling, means the ratio of cases, incidents, or files in error in relation to the total sampled in a Division examination or investigation.

(d) **"Examinations"** means a formal financial examination or market conduct examination, as well as informal investigations conducted by the Commissioner for the purpose of determining compliance with the law. Examinations may include routine, targeted, follow-up, multi-state, or desk examinations.

(e) **"Investigation"** means any official formal or informal Division review, analysis, inquiry, and/or research into referrals, complaints, or inquiries to determine the existence of violations.

(f) **"Person(s)"** means any person or entity engaged in the business of insurance or other persons or entities regulated by the Commissioner of Insurance.

(g) **"Regulation"** includes any and all insurance regulations adopted by the Commissioner, which apply to regulated entities.

(h) **"Violation"** means non-compliance with applicable statutes, regulations, stipulations or orders, regardless of whether the person acted in good faith, or whether the person actually knew the conduct was not in compliance. Each enumerated exception or recommendation in a financial or market conduct examination, an investigation, or each separate actual occurrence is a separate violation. Each and every

violation may result in a penalty, although it is within the discretion of the Commissioner, or his/her designee, to determine that a penalty will not be imposed for a particular violation.
(i) **"Willful"** means any act of commission or omission that the person knew or reasonably should have known was a violation of the insurance statutes or regulatory acts, a general business practice, or a violation committed with a frequency that indicates a tendency to engage in acts substantially similar to a prior violation.

(4) General Provisions.

(a) All fines assessed are due and payable immediately with checks made payable to the Colorado Division of Insurance. Attach a copy of the statement or letter assessing such fine. Send all remittances to the Colorado Division of Insurance, "ATTENTION: Cash Management".
(b) Guidance to Promote Voluntary Settlement. As the result of market conduct and financial examinations of insurance companies, recommendations are made to the regulated person when violations of the statutes are indicated. The Commissioner encourages voluntary resolution of compliance issues and the incorporation of such compliance plan in the form of stipulation in a final order.
(c) Fines and Penalties are Determined by Commissioner. The Commissioner or the Commissioner's designee shall determine appropriate fines or monetary penalties.
(d) Response to Division Inquiries. The mission of the Division of Insurance is consumer protection; therefore, the failure of persons to respond to Division inquiries, comment forms, or complaints in accordance with Regulation 6-2-2 is viewed as willful noncompliance, even if the person's position is ultimately supported. Therefore, a penalty of up to $1,000 will be assessed for violation of Reg. 6-2-2.
(e) Guidelines Do Not Limit Commissioner's Authority. These general guidelines shall not supersede the Commissioner's authority to suspend, revoke or refuse to renew a person's certificate of authority, to issue a cease and desist order, to initiate criminal proceedings, to apply for injunctive or other equitable relief, or to require specific other corrective actions in cases in which the imposition of administrative penalties may not be appropriate. It is within the Commissioner's authority to evaluate each case separately. The imposition of a fine in one situation will not limit the Commissioner's discretion to impose a greater or lesser penalty in another case or to take such further administrative action as is warranted by the circumstances.
(f) Use of Error Ratios in Examinations. Error ratios exceeding 10% are deemed to be serious violations for purposes of calculating fines and penalties. Violations based upon error ratios of between 5% to 10% may be charged with fines or penalties depending on the seriousness or the willful nature of the violation. Violations based upon error ratios of less than 5% may be deemed not serious violations and not subject to penalty, unless, for example, the consumer impact is great or a general business practice is evidenced. Regardless of whether the error ratio for any violation(s) is less than, equal to, or exceeds the permissible error ratio for fining purposes, the Commissioner may require corrective action. Violation(s) discovered as a result of a Division investigation into a consumer complaint are not subject to the error ratio provisions of these guidelines, unless a limited, targeted or desk examination is triggered by the complaint.
(g) Prior Corrective Activities. The Commissioner may waive a fine for violations for which successful corrective activities were initiated and implemented by the insurer before the violation was noted in examination or otherwise brought to the attention of the Commissioner. Such corrective activities may include remedial procedures put in place to assure that the violation does not recur, personnel actions taken when appropriate, and making any injured party whole.
(h) Impact of Penalty on Solvency. The Commissioner may reduce the amount of a penalty that would otherwise be imposed pursuant to these guidelines if the payment of such a penalty would reduce surplus to an extent that the company is insolvent pursuant to §10-3-812, C.R.S.
(i) Penalty Calculation. Penalties for each separate violation(s) are cumulative, subject to aggregate limitations, and will consider all factors that determine the seriousness of the violation(s), as listed below.
(j) Form Filings. Regulated persons filing health, private passenger automobile, and claims made policy forms, that do not receive prior approval from the Division, certify that the forms are in compliance with the insurance laws of Colorado. Therefore, the Division will presume "willfulness" for purposes of penalty calculation where violations are found.

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Regulated persons are required to have prior approval for policy forms issued for certain lines of insurance. Therefore, the Division will presume "willfulness" for the purposes of penalty calculations when a person is found using such a form without prior approval.

(k) Rate Filings. Regulated persons are required to file and, in some cases, receive prior approval before instituting rates. Therefore, the Division will presume "willfulness" for purposes of penalty calculation where rates are used without having been previously filed and/or approved, as required.

(l) Imposition of Penalties. A person may be penalized for two actions:

- A penalty imposed for violation of statute, rule, regulation or order of the Commissioner. Such fine or penalty is due and payable immediately;
- A second separate penalty may be levied upon a company's failure to initiate corrective action, or other measures, as ordered by the Commissioner.

(m) Factors to be Applied in Determining Seriousness of Violation. The following factors may be considered in establishing the degree of seriousness of the violation(s) for purposes of determining the appropriate penalty:

- Whether the person knew or reasonably should have known that its conduct was in violation;
- Frequency of the violation and related violations that, when viewed in the aggregate, evidence general business practices;
- Impact on the availability of benefits to the consumer;
- Cooperation or lack of cooperation of the person;
- Costs involved in remedying the problem or in making restitution to affected consumers;
- Corrective activities that are substantially initiated only after the violation or possibility of violation is formally noted or brought to the attention of the person by the Commissioner;
- Severity of actual financial harm or other damage to any insured, claimant, applicant, or other person(s) caused directly or indirectly by the violation;
- Degree of potential harm to which any insured or claimant was exposed by the violation;
- Financial gain or loss to the insurer from the violation;
- Whether the conduct is a similar or repeat violation;
- Previous fines, penalties or enforcement imposed by the Commissioner against the person for unrelated conduct.

(n) All fines and penalties arising through market conduct or financial examinations, from producer violations, or through consumer complaints that may indicate a general business practice, will be reported as they occur to the National Association of Insurance Commissioner's RIRS or SAD database services.

Penalty Guidelines

The following statutory references are noted to assist the reader in understanding the fining authority of the Division of Insurance. The failure to list a statutory reference to a penalty provision in this section does not impact the applicability of the enforcement guidelines to a possible violation.

Market Conduct Examinations §10-1-205, C.R.S.
Financial Examinations §10-1-205, C.R.S.

After consideration of the financial or market conduct examination: §10-1-205 (3)(d), C.R.S., states that the Commissioner may impose:

For Negligent Violations: A penalty of not more than $1,000 for every act in violation of law described in the report, not to exceed an aggregate penalty of $10,000.

For Willful Violations: A penalty of not more than $10,000 for every act or violation, not to exceed an aggregate penalty of $150,000 in any six-month period.

Unfair Methods of Competition and Unfair Acts or Deceptive Practices §10-3-1104, C.R.S.
Violations of "No Fault" Insurance Act §10-4-701, C.R.S., et seq.
Violations of other provisions of Title 10 § 10-3-1107, C.R.S.
Violations of any rule or lawful order of the Commissioner § 10-3-1107, C.R.S.

For "Negligent" Violations: A penalty of not more than $1,000 for every act in violation of law described in the report, not to exceed an aggregate penalty of $10,000.

For "Willful" Violations: A penalty of not more than $10,000 for every act or violation, not to exceed an aggregate penalty of $150,000 in any six-month period.

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Violations of Cease and Desist Orders §10-3-1109, C.R.S.

A person or insurer who violates a cease and desist order issued by the Commissioner after notice and hearing, may be subject to:

Individuals: a penalty of $500 for each act of an individual

Insurers: a penalty of not more than $10,000 for each and every act of an insurer

Insurers: An insurer who violates a cease and desist order subject to §10-3-904.6(5), C.R.S., regarding unauthorized business of insurance, may, after notice and hearing, be subject to a civil penalty of $25,000 for each act of violation.

Violations of Holding Company Act §10-3-810, C.R.S.

Any insurer, director, officer, employee or agent who fails to file a registration statement, amendment, or notice or shareholder distribution, may be subject to, after notice and hearing:

A civil penalty of not more than $5,000, depending on the seriousness of the violation.

Willful violations of other provisions of part 8 by companies or responsible directors, officers, employees or agents of the company are subject to criminal penalties in accordance with §18-1-105, C.R.S., or a fine established by the commissioner and agreed to in writing by the insurer in lieu of criminal action.

Violations of Licensing and Appointment of Insurance Producers §10-2-401 and for Termination of Appointment §10-2-416, C.R.S.

Any insurer who is in violation of §10-2-416, regarding termination of agent appointment(s), shall be subject to a fine of $1000 for each such failure or refusal to comply.

Violations of Licensing Requirements for Producers §10-2-804, C.R.S.

Any person who is in violation of this section may, after notice and hearing, have his/her license to engage in the business of insurance denied, suspended, revoked, or refused to renew; or, in appropriate instances, in addition to or lieu of the above, the Commissioner may order a fine of not less than $1000 for each offense.

Violations of Licensing Requirements for Bail Bondsman §12-7-106, C.R.S.

Any person who is in violation of this section may, after notice and hearing, have his/her license to engage in the business of professional bondsman denied, suspended, revoked, or refused to renew; or, in appropriate instances, in lieu of the above, the Commissioner may, in any one proceeding, order a fine of not less than $300 nor more than $1000 for each offense.

Violations of Regional Home Application Requirements §10-3-209(II)(B), C.R.S.

Any person who files an application for qualification of an office in the state of Colorado as a regional/home office may be charged a late fee of $100 per day for each day after March 1 of the application year the application is filed. Applications received after March 31 shall be denied.

Violations of Preneed Contract Licensing Requirements §10-15-103(5)(a), C.R.S.

A late charge of $100 per day may be imposed upon any person for the delinquent filing of the renewal application.

Violations of Contract Seller Regulations §10-15-114(1), C.R.S.

Any contract seller who is in violation of this section may have an administrative fine imposed not to exceed $1000 for each separate offense, or other sanctions of the Commissioner.

Violations of Reinsurance Intermediary Regulations §10-2-901, et seq., C.R.S.

A reinsurance intermediary, insurer or reinsurer who is in violation of this section may be charged a fine not to exceed $5,000 for each separate violation.

Violations of Managing General Agents Regulations §10-2-1001, C.R.S.

Any person who is in violation of this section may be charged a fine not to exceed $5,000 for each separate violation.

Late Filing Penalties for Required Documents §10-3-109, C.R.S. and
Regulation 3-1-10, "Financial Statement Filings, Accounting Standards and Reporting of Liabilities"

Listed separately in attachment

For further information:

Consumer Affairs Section
Colorado Division of Insurance
1560 Broadway, Suite 850; Denver, Colorado 80202
(303) 894-7490 phone; (303) 894-7455 fax

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FINANCIAL ANALYSIS
SUMMARY OF MOST COMMON FILING REQUIREMENTS AND RELATED LATE FILING PENALTIES

Description of Filing	Due Date (date by which filing must be received)	Colorado Revised Statute or Regulation
Annual statement	March 1	10-3-109(2) or 10-16-420
Individual annual statement pages	March 1	10-3-109(2) or 10-16-420
Quarterly statements	May 15, August 15, November 15, per NAIC instructions	10-3-109(3) or 10-16-420
Monthly statements	45 days after month-end by Commissioner declaration	10-3-109(3) or 10-16-420
Annual statement synopsis for publication	March 1	10-3-109(2)
Business Plans, if applicable	Within the time period specified by the Commissioner	10-3-109(3) or 10-16-420
Audited financial report	June 1	10-3-109(2) or 10-16-420
Accountant's letter of qualifications (see audited financial report)	June 1	10-3-109(2) or 10-16-420
Designation of Independent CPA	within 60 days after becoming subject to the requirement to file	10-3-109(3) or 10-16-420
Notification of change in auditor	within 5 working days	10-3-109(3) or 10-16-420
Notification of disagreements between auditor and company and accompanying auditor letter, (only domestic companies are required to file)	within 10 working days of notification of change in auditor	10-3-109(3) or 10-16-420
Request for permission to file consolidated or combined audits, (only domestic companies are required to file)	December 31, by Commissioner declaration	10-3-109(3) or 10-16-420
Notification of adverse financial condition, if applicable, (only domestic companies are required to file)	within 5 business days of receipt of report	10-3-109(3) or 10-16-420
Report on significant deficiencies in internal control, if applicable; along with company's description of remedial actions taken or proposed to correct significant deficiencies	within 60 days after filing of audited financial statements	10-3-109(3) or 10-16-420
Fidelity bonds	within 30 days after execution	10-3-109(3) or 10-16-420
Disclosure of material transactions	15 days after the end of the calendar month in which the transaction occurs	10-3-109(3) or 10-16-420
RBC reports of domestic companies	March 1	10-3-109(2)
RBC Plan, if applicable	within 45 days of event requiring a plan to be filed	10-3-109(3)
Holding company registration statements (Forms "B" and "C")	within 120 days of the UCP's fiscal year end	Reg. 3-4-1
Statutory deposit quarterly report on market value	within 30 days of the end of each quarter, i.e., April 30, July 30, October 30 and January 30	10-3-109(3) or 10-16-420
Actuarial Opinion	March 1	Reg. 3-1-3, Reg.3-1-8(V)(a)(4)
Actuarial Report for companies which establish an amount less than the actuary's best estimate, as indicated in the underlying actuarial report, or if requested by the Commissioner	No later than 30 days following either the due date of the opinion or the date requested by the Commissioner	Reg. 3-1-3

Penalties levied pursuant to §10-3-109(3), C.R.S. are limited to a maximum of $500 for an initial violation and $5,000 for each subsequent violation.

*If both the audit report and accountant's letter of qualifications are delinquent, the combined penalty for both delinquencies is $100 per day.

** HMOs should refer to §10-16-420, C.R.S. for applicable penalty maximums.

KENTUCKY ENFORCEMENT OPTIONS

In Kentucky, once the Market Conduct unit delivers a report to the company and allows a period of time for the company to respond to the report, Market Conduct drafts a proposed Agreed Order to tender to the Commissioner.

The recommended Agreed Order contains proposed civil penalties that are calculated, in part, based on the following formula:

File population (Error Percentage - Error Tolerance) x $100.

This formula is utilized because is applies the error percentage to the entire file population in a particular test. At times, the use of this formula may yield penalties that are extraordinary. For this reason, the maximum penalty for any given violation is determined to be $10,000***** plus 10% of the product produced by the formula, unless circumstances indicate that a larger penalty (or smaller penalty) is warranted. If a violation is one that is reoccurring throughout the examination, the penalty will be calculated by averaging the population and the error percentages for the multiple lines of business to derive one set of factors for use in the formula.

Penalties are generally only assessed for violations that amount to a general business practice (error percentages that exceed the error tolerance guidelines established by the NAIC). However, there is zero tolerance for some penalties (such as agent/adjuster/broker licensing, forms in use that were not approved by the DOI, and record retention violations). Generally, the penalty for these violations is $1,000 per violation. However, if the company has serious record retention violations, the penalty might increase up to $5,000 per violation.

Factors that may affect the amount of the penalty include the following:

1. The type of law violated (consumer protection versus administrative). Were consumers harmed by the violation?
2. Action taken by the licensee to correct the violation (i.e. Did the company do a self-audit to determine further effects of the violation on the insured? Did the company pay restitution to the affected policyholders?)
3. Did the company find and take action with respect to the violation prior to the market conduct examination?
4. Is there a good legal argument or is there a legal basis for the company's action?
5. Does the company accept the DOI's interpretation of the law or does the company take an adversarial position that is unfounded or frivolous?
6. Is the violation a first-time violation (at least the first time the DOI discovered the violation) or a repeat violation (found in previous exam or consumer complaint)?

In addition to the penalties, it is customary for the Agreed Order to contain remedial/corrective measures to be taken by the company. The remedial/corrective measures may apply to those violations that were not general business practices as well as those that were. Also, the proposed Agreed Order may contain requirements that the company pay restitution, if applicable. Lastly, the Agreed Order may contain, as an exhibit, amendments to the report if there were found to be errors or misstatements in the report.

*****Note: KRS 304.99-020 permits penalties of not more than $10,000 per violation against insurers; $1,000 per violation against agents, brokers, and solicitors; and $2,000 per violation against adjusters, administrators, and consultants. These are maximum penalties. The statute allows the commissioner great discretion up to these maximums. KRS 304.99-020 is the general statute regarding penalties. The Kentucky Insurance Code also lists specific statutory penalties for specifically named violations. Those are not outlined in this document but I will supply those if requested.

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MARKET CONDUCT EXAMINATION INSTRUCTIONS

I. COMPANY SELECTION

Company[1] selected

Each state should develop a standard planning process for its market conduct examinations that incorporate data from various sources including, but not limited to, annual statements, market share reports, complaint data, complaint indices, recent filings, department records/information, etc. A state will apply the criteria, which it has established for calling examinations, to the information developed from the standard planning process in order to determine which insurers should be examined An examination call sheet and supporting documentation should be collected at this time. [See example 1.[2]]

Please also refer to the items listed in exhibit A1[3] of the Uniformity Outline for a list of possible reasons for calling an examination.

See also the Market Analysis How-to Guide [*work in progress*].

Justification of examination

A memorandum should be prepared by summarizing all relevant data used to determine the necessity of the examination. A Call Sheet should be prepared, along with the examination plan and estimated time sheet, and submitted to the appropriate department personnel for his/her approval. The proposed examination memorandum is approved, disapproved, or returned to Staff with instructions to obtain additional information. [4]

Internal data requested from department

Prior to an examination being approved, specific information should be compiled from the various sections within the department. Examples of this information include: licensing (insurer lines of authority, agent/agency appointments), consumer complaints (number and types of complaints), market regulation and compliance history, rates and forms filings, financial analysis and examination, etc. A notice [e.g. via email] should be sent to the sections informing them that an examination of the company will commence and asking for any other relevant information. [5]

[1] Company or Group Entity
[2] Copy of examination call sheet and examination justification memo.
[3] Excerpt from Uniformity Outline showing reasons for calling an exam
[4] Example of Exam Justification Memo
[5] copy of our exam checklist document; memos to the sections;

Scope of examination

The areas to be covered by the examination [e.g., underwriting only or claims only], the line(s) of business, as well as the time period under review must be clearly defined. The location of the examination must be determined - e.g., corporate headquarters or regional offices. The scope should include a preliminary estimate of timing and costs.

Selection of examiner in charge (EIC) and team

The EIC is the onsite supervisor of the examination team. The examination team may be comprised of one or more examiners in addition to the EIC. When selecting the examination team, states should match examiners' areas of experience to the appropriate examination.

Anticipated duration determined/examination plan/time plan [6]

A final examination plan, including an estimate of the duration and cost of the examination, should be completed by the EIC as soon as possible. Final adjustments should be made within first two weeks of the examination and communicated to the company.[7] The examination plan needs to reflect actual field discoveries as to the quality and availability of data, the level of the company's cooperation, the location of the data, etc. As the examination matures, the EIC may need to adjust the examination plan. The company should notified of any changes and the justification.

II. COMPANY NOTIFICATION

Notice of examination reported to ETS

Examinations need to be entered into the ETS no later than sixty (60) days before the expected date of the onsite examination. Exceptions to this rule are examinations that are called to respond to more immediate concerns.

Notice of examination sent to company

A company approved for an examination is notified of the pending examination by letter. The letter should be accompanied by an examination coordinator's handbook or information packet. The letter should also briefly explain the examination process. If more than one company within a group of companies is being examined, the state should clearly indicate which companies are being examined.[8] See the Uniformity Outline B.2.a for notification requirements.

[6] copy of examination plan, worksheet, time estimate
[7] copy of final examination plan with name deleted
[8] copy of exam notice letter

Pre-examination handbook sent to company

A preliminary examination handbook or information packet should be sent to the examination coordinator at least thirty (30) days before the estimated commencement of the onsite examination. An exception to this rule, are examinations called to respond to immediate concerns.

The preliminary packet should contain the following information: the scope of the examination, general instructions, the materials requested to perform the examination, data call examples, requirements for accommodations and supplies, time and cost estimates], travel information, specific instructions regarding sampling, location of on-site examination, security arrangements, billing procedures, communication processes with the company and the department, and any other pertinent information. [9]

Company identifies examination coordinator(s)

Prior to the commencement of the examination the company must identify company personnel who will have the authority and responsibility to respond to the criticisms of the examiners as well as provide additional information as needed. {See example of response sheet.} [10]

Company responds to appendices /other requested information received

The insurer is instructed to respond to the department by a specified date with answers to various questionnaires[11] or interrogatories[12] contained within the preliminary packet as well as provide any other requested information by the date specified.

III. EXAMINATION TEAM

Examination audit plan drafted

A state shall determine the phases and/or standards of the examination that are to be reviewed. An estimate of the amount of time required to conduct each phase of the examination should be made, with the understanding that additional time may be necessary depending upon the findings of the examination. The type of information to be included in an Audit Plan is as follows: the scope of the examination, the justification for the examination [summarized], the lines of business to be examined, company procedures to be examined/omitted and the reasons for doing so, a time estimate, and an identification of factors that will be included in the billing. [13]

Determine the type of Report to be prepared-either one by test or one by exception, as prescribed by the NAIC Examiners Handbook.

[9] copy of pages from pre-exam packet
[10] copy of response page from packet
[11] copy of appendices
[12] copy of interrogatories from NC
[13] copy of examination plans and time estimations

Initial examination team meeting, including contractors [Optional]

States that use contract firms must determine goals, restrictions, procedures, oversight, and billing procedures. It is recommended that the department meet with the examination team prior to the team going on-site. To the extent possible, instructions provided to contractors should also be shared with the company.

Pre-examination contact

Under ordinary circumstances the EIC will contact the company coordinator prior to the beginning of the examination and make all necessary arrangements. This contact may be by telephone, a letter, or a pre-examination visit. It is during this pre-examination contact that the work space, data requests, necessary supplies, office equipment and other examination details should be discussed. [14] The EIC will also make the necessary arrangements to begin the field portion of the examination.

Pre-examination visit - optional

See above.

IV. DATA / FILES

Data requests are provided to the company

Detailed instructions for these data requests should be provided in the pre-examination packet. States should utilize the uniform data requests or inform the company that they will be supplying alternative data requests. The request should clearly state the file type, format and medium. Examples of data requests are policy types by policy number and issue date; claim types by claim number and date received; commissions paid by name, date, and amount; producer contracts by name and effective date; policy forms by type and first date of use; etc. Upon receipt, the examiner should validate these data.

Data received from the company

File selection may take place in advance of the examination team's or upon arrival at the examination location. The EIC may instruct the company, prior to his/her arrival, or upon arrival, of the files to be pulled or reports to be provided when the on-site examination begins.

EIC reviews appendices/other requested information

The EIC should review the company's responses to the questionnaires and/or interrogatories, and request any additional information needed.

[14] sample of ltr from EIC

Samples determined

Depending on the circumstances, the examiners will use company provided printouts, ACL, or other methods necessary to select the files for the sample or census review.

For further information related to the sampling process please refer to Chapter 5 of the Handbook

V. EXAMINATION STAGE

Once the examination team has arrived on-site, the EIC should take this opportunity to introduce him/her and the team members. The EIC should explain the examination process to the company coordinator. If the examiners have any special needs or additional requests now would be the time to communicate them to the company.

Request for information (crits)

When an examiner perceives a violation of a statute, regulation, or policy provision, or a rating, underwriting, claim, or producer licensing error, the company will be provided a written form requesting an explanation of the error or a written acknowledgment of the error. This form is commonly referred to as a criticism or a "crit" sheet. The criticism and the company's response becomes a part of the examination documentation. The company is allowed a specified time period to respond. [15]

Summary of findings

Upon completion of the file reviews the examination team prepares a report of their findings. The examiners should share the summary with the company.

Final examination team meeting

Upon completion of the field work of the examination the EIC should offer to conduct an exit meeting with the company to discuss significant findings, explain the next steps in the examination process, and allow the company to present any outstanding concerns. The EIC should not re-argue the findings of the team at this time.

[15] copy of crit form and formal response

MARKET CONDUCT EXAMINATION CHECKLIST

Company Name: _____

NAIC Company Code: _____ NAIC Group Code: _____

Company Home Office Location: _____

Exam Site Locations: _____

I. COMPANY SELECTION

Complete	Date Completed	Examiner(s)	Due Date	Task
☐	_____	_____	_____	1. Company selected
☐	_____	_____	_____	2. Justification
☐	_____	_____	_____	3. Internal data request
☐	_____	_____	_____	4. Scope of examination
☐	_____	_____	_____	5. Examiner in charge (EIC) and team named
☐	_____	_____	_____	6. Anticipated duration determined

II. COMPANY NOTIFICATION

Complete	Date Completed	Examiner(s)	Due Date	Task
☐	_____	_____	_____	1. Notice of examination reported to ETS
☐	_____	_____	_____	2. Notice of examination sent to company
☐	_____	_____	_____	3. Pre-examination handbook sent to company
☐	_____	_____	_____	4. Company appoints examination coordinator
☐	_____	_____	_____	5. Company responds to appendices received

III. EXAMINATION TEAM

Complete	Date Completed	Examiner(s)	Due Date	Task
☐	_____	_____	_____	1. Examination audit plan drafted
☐	_____	_____	_____	2. Initial team meeting (contractors) Optional

☐	_____	_____	_____	3. Pre-examination contact
☐	_____	_____	_____	4. Pre-examination visit (optional)
☐	_____	_____	_____	5. Complete all necessary travel arrangements

IV. DATA / FILES

Complete	Date Completed	Examiner(s)	Due Date	Task
☐	_____	_____	_____	1. Data requests to company
☐	_____	_____	_____	2. Data received from the company
☐	_____	_____	_____	3. EIC review appendices/other requested information
☐	_____	_____	_____	4. Samples determined and sent to the company

V. EXAMINATION STAGE

Complete	Date Completed	Examiner(s)	Due Date	Task
☐	_____	_____	_____	1. Request for information (crits)
☐	_____	_____	_____	2. Interim conferences
☐	_____	_____	_____	3. File sampling
☐	_____	_____	_____	4. Summary of findings
☐	_____	_____	_____	5. Final examination team meeting
☐	_____	_____	_____	6. Offer to hold exit meeting

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